NEUROLOGICAL GROUP, PC
MEDICAL QUESTIONNAIRE

Name (Legal Name):________________________

Nickname:________________________________

Address:
Street:_________________________________
City:__________________State_____Zip_____

Mailing Address: (if different)
Street or PO Box: _______________________
City: __________________State_____Zip____

Patient's Employer:________________________

Birth Date:_______________________

Maiden or other name:_____________

E-mail address:__________________

Social Security #:_________________

Patient's Home Phone #:___________
Cell phone #:____________________
Other phone#:___________________

Patient's Work Phone #:____________

Any special requests regarding communication with you? ___________________________________

Emergency Contact Person:_________________
Relationship:_____________________________

Emergency contact's phone numbers:
Home:___________Work:___________

Who is your primary care doctor?
____

What pharmacy do you use?________________

Who referred you to this office?
____

INSURANCE INFORMATION (Primary)
Name of carrier______________________________
Policy #: __________________________________
Group#: __________________________________

Insured's date of birth: ______________
Insured's SS#:_____________________
Phone#: _________________________

INSURANCE INFORMATION (Secondary)
Name of carrier_____________________________
Policy #: _________________________________
Group#: _________________________________

Insured's date of birth: ______________
Insured's SS#:_____________________
Phone#: _________________________

FINANCIAL AND PRIVACY POLICY (PLEASE READ CAREFULLY)

Charges for medical services are due and payable by the patient at the time of service. Co-payments, deductibles and coinsurance are due at the time of service for Medicare and other Insurance Plans that are accepted by this office. Obtaining proper referrals to this practice is the patient's responsibility and, if proper referrals are not obtained, the patient is responsible for payment in full for professional services rendered. Charges for patients with insurance plans we do not participate with are due and payable in full at the time of service. The patient is responsible for all fees, regardless of insurance coverage. Motor vehicle and liability claims are the patient's responsibility. If patient misses an appointment, a $25.00 fee will be charged. The patient is liable for all collection costs (collection agency fees, legal fees and court costs) in addition to professional fees charged by this practice. Checks returned by the bank will incur a $25.00 service fee. I have read the above and request that all payments by my insurance carrier, including Medicare, be paid directly to the Neurological Group, PC. I also authorize the release of any medical or other information to my insurance carrier necessary to process my claims. **The signature below acknowledges that I have received a copy of Neurological Group's Privacy Policy. I have read and understand its contents and agree to abide by the terms and conditions therein**.

Signature of patient / guardian: __________________________________Date:________________

FOR WORK-RELATED INJURIES ONLY:

Date of Injury: ____________________________ Employer: ________________________
Was injury reported? _______________________ To Whom?________________________
What dates have you missed from work: ____
What was the first day you were out of work? ______________________________
Worker's Comp. Carrier: ___________________ CLAIM#: _________________________
Adjuster's Name: _________________________ Carrier/Adjuster's Phone#:
Do you have an attorney? __________________ ___________________________________
Firm name and address: ____________________ Attorney's Phone #:_________________

FOR AUTO ACCIDENTS ONLY:

Date of Accident:__________________________ Where did accident occur?
Do you have an attorney?___________________ _________________________________
Firm name & address:_____________________ Attorney Phone #:

MEDICAL HISTORY:

List all medications, doses & frequency (including over-the-counter medications):
1)____ 6)________________________________
2)____ 7)________________________________
3)____ 8)________________________________
4)____ 9)________________________________
5)____ 10)_______________________________

List any alternative therapies, herbal medicines, dietary supplements, etc:
1)____ 3)________________________________
2)____ 4)________________________________

List all allergies (medications, foods, environmental, etc):
1)____ 3)________________________________
2)____ 4)________________________________

What are your current complaints? (What are you being seen for today?)
____
____

Is this condition related to any injury or accident? Please describe:___________________
____

Are you right or left handed?______________

Have you ever had surgery? If so, please list below:
1)____ 4)________________________________
2)____ 5)________________________________
3)____ 6)________________________________

Do you have a history of any of the following? (Please circle)

AIDS
Anemia
Arthritis
Asthma/emphysema
Atrial Fibrillation
Cancer
Congestive heart failure
Coronary artery disease
Dementia
Depression
Diabetes
Emphysema
Gallbladder disease
Glaucoma
Hepatitis
High blood pressure
HIV
Kidney infections
Kidney stones
Lyme disease
Migraines
Multiple sclerosis
Pacemaker
Parkinson's Disease
Phlebitis, blood clots
Pneumonia or bronchitis
Polio
Prostate disorders
Psychiatric disorders
Seizures
Serious Injuries
Sexually transmitted disease
Sinus infections
Stomach ulcers
Stroke
Thyroid disease
Traumatic brain injury
Tuberculosis

Additional medical history or comments:

____

____

Have you had any of the following symptoms? (Please circle)

Back pain
Balance problems
Bladder problems
Bloody sputum
Chest pain, angina
Chronic cough
Chills
Circulatory problems
Cold hands/feet
Confusion
Depression
Difficulty walking
Dizziness or vertigo
Easy bruising
Fainting
Fatigue
Fever
Gastrointestinal problems
Glandular problem
Hormone problem
Headaches
Hearing loss
Heat/ cold intolerance
Irregular periods
Joint pain
Limb weakness
Loss of appetite
Memory loss
Muscle aches
Muscle cramps
Nausea/vomiting
Neck pain
Numbness
Paralysis
Pinched nerves
Problems with urination
Prostate problems
Rash or itching
Sexual problems
Shortness of breath
Sleep problems
Speech problems
Swelling in joints
Tender muscles
Tremors
Visual disturbances
Weight loss
Writing problems

Additional complaints or comments:

____

____

List any medical providers you are currently being treated by: __________________________

____

EMPLOYMENT HISTORY:

Employment status: ___ retired ___employed ___disabled ___student ___ other

If disabled, when did you last work? ____

What type of work do you do?____

How long have you been at your present job?_________________________________

SOCIAL HISTORY

Are you currently a smoker?____________ Have you ever smoked?_____________

How much?______________________

Do you drink alcohol?_________________ How much?_______________________

Do you have a history of illegal drug use?____________________

Marital status:______________________ Education:_________________________

Primary Language: _______________________

Race:_____________________________ Ethnicity: __________________________

Have you ever been a victim of violence or abuse? _______________________________

FAMILY HISTORY:

Please check if any relative (parents, siblings, grandparents, children) have had any of the conditions listed below:

High blood pressure:	______	Kidney Disease:	______	Asthma:	______
Stroke:	______	Bleeding Disorders:	______	Tuberculosis:	______
Cancer:	______	Emphysema:	______	Colitis:	______
Seizures:	______	Heart Disease:	______	Anemia:	______
Diabetes:	______	Ulcers:	______	Mental Illness:	______
Multiple Sclerosis:	______	Gout:	______	Headaches:	______
Dementia	______	Migraine:	______		

Other Serious Illness:____

Provide additional information on condition checked:__________________________________

____

COMMENTS

Any other information you feel may be helpful to the physicians regarding your medical history, your current condition or treatment:

____
____
____